STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155222	A. BUILDING 01 B. WING	09/22/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINDRED TRANSITIONAL CARE AND REHAB-KOKOMO	429 WEST LINCOLN ROAD KOKOMO, IN46902

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K0000	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a). Survey Date: 09/22/11 Facility Number: 000127 Provider Number: 155222 AIM Number: 100291430 Surveyor: Phillip Komsiski, Life Safety Code Specialist At this Life Safety Code survey, Kindred Transitional Care and Rehabilitation-Kokomo was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This one story facility was determined to be of Type II (000) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, spaces open to the corridors and resident rooms on north unit (100 hall).	K0000	This Plan of Correction is the centers Allegation of compliance.Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed soley because it is required by the provision of federal and state law.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	The facility has a capacity of 131 and had a census of 99 at the time of this survey. Quality Review by Lex Brashear, Life Safety Code Specialist-Medical Surveyor on 09/28/11. The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:			
K0051 SS=E	A fire alarm system with approved components, devices or equipment is installed according to NFPA 72, National Fire Alarm Code, to provide effective warning of fire in any part of the building. Activation of the complete fire alarm system is by manual fire alarm initiation, automatic detection or extinguishing system operation. Pull stations in patient sleeping areas may be omitted provided that manual pull stations are within 200 feet of nurse's stations. Pull stations are located in the path of egress. Electronic or written records of tests are available. A reliable second source of power is provided. Fire alarm systems are maintained in accordance with NFPA 72 and records of maintenance are kept readily available. There is remote annunciation of the fire alarm system to an approved central station. 19.3.4, 9.6 Based on observation and interview, the facility failed to ensure 3 of 22 smoke detectors on 100 hall were installed in a location which would allow the smoke detector to function to its fullest capability. NFPA 72, 2-3.5.1 requires in	K0051	K0051A. Smoke detectors identified in the statement of deficiency for 100 hall was replaced.B Any resident that resides on 100 hall had the potential to be affected, however no negative outcomes were identified.C. Smoke detectors will	10/22/2011

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	spaces served by air handling systems, detectors shall not be located where air flow prevents operation of the detectors. This deficient practice could affect 30 residents on 100 hall as well as visitors and staff. Findings include: Based on observations on 09/22/11 during the tour between 12:45 p.m. and 1:20 p.m. with the Maintenance Supervisor, the following smoke detectors were within three feet of an air diffuser. a. One smoke detector to the north of the North Nurses' station was within two feet of an air supply vent. b. One smoke detector next to room 115 on North 100 hall was two feet from an air supply vent. c. One smoke detector on 100 hall west at the end of the hall next to the exit was two feet from an air supply vent. Based on interview on 09/22/11 concurrent with each observation, it was acknowledged by the Maintenance Supervisor the aforementioned smoke detectors were installed within three feet from an air supply duct in the ceiling which would interfere with the smoke detector's ability to detect smoke to its fullest capability. 3.1-19(b)		be placed at least 3 feet from exhaust vents. Maintenance personel was educated on the components of K0051.D. Monitoring of this tag will be the responsibility of the Executive Director/designee.Observational rounds weekly times 3 months, then quarterly thereafter to ensure that smoke detectors are installed correctly.Results of monitoring will be taken to Performance Improvement meeting monthly to determine continued compliance and/or until the committee recommends discontinuation of monitoringE. 10-22-2011	

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K0066 SS=F	Smoking regulations are adopted and include no less than the following provisions: (1) Smoking is prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area is posted with signs that read NO SMOKING or with the international symbol for no smoking. (2) Smoking by patients classified as not responsible is prohibited, except when under direct supervision. (3) Ashtrays of noncombustible material and safe design are provided in all areas where smoking is permitted. (4) Metal containers with self-closing cover devices into which ashtrays can be emptied are readily available to all areas where smoking is permitted. 19.7.4 Based on observation, record review and interview, the facility failed to ensure 1 of 1 areas where smoking was permitted was provided with metal containers with self closing covers into which cigarette butts could be extinguished. This deficient practice could affect 3 staff observed in the smoking shack southeast of 400 hall where residents and visitors were also allowed to smoke. Findings include: Based on observation on 09/22/11 at 2:00 p.m. with the Maintenance Supervisor, the	K0066	K0066A. Smoking recepticles were immediately covered.B. No resident was identified to have been affected.C Effective 10-1-2011 Kindred Transitional Care and Rehabilitation became "smoke free" for staff. Ashtrays were removed from smoking areas outside 400 hall. No smoking signs posted on entrance/exit doors. Staff in-serviced on no smoking policy.D. The monitoring of this tag will be the direct responsibility of the Executive Director/Designee.Observational rounds 3 times weekly for 6 months then random weekly observations for 6 months will be	10/22/2011

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	smoking area outside 400 hall southeast was provided with open metal containers without self closing covers where over one hundred cigarette butts were deposited. In addition, an alternate smoking site adjacent and east of the smoking shack had a metal tray without a self closing cover where over one hundred cigarette butts were deposited. Based on record review on 09/22/11 at 3:15 p.m. the smoking policy indicated cigarettes would be deposited into a metal container with a self closing cover. Based on interview on 09/22/11 concurrent with each observation it was acknowledged by the Maintenance Supervisor metal containers with self closing covers were not provided in the smoking shack or just outside and to the east of the smoking shack. 3.1-19(b)		completed to ensure that self closing cover is present on metal ashtrays. Only ashtray present will be at front entrance for visitors to extinguish prior to entry.Results of this monitoring will be taken to Performance Improvement meeting monthly for review to determine continued compliance and or until the committee recommends discontinuing of monitoring.E. 10-22-2011	
K0069 SS=E	Cooking facilities are protected in accordance with 9.2.3. 19.3.2.6, NFPA 96 Based on observation and interview, the facility failed to install and maintain 1 of 1 cooking facilities in accordance with the requirements of NFPA 96, 7-2.1.1 which requires a placard identifying the use of all extinguishers as a secondary backup means to the automatic fire suppression system shall be conspicuously placed near each portable fire extinguisher in the cooking area. Additionally, NFPA 10,	K0069	K0069A. Placard was immediately placed above the extinguisher in the cooking facility.B. No residents were identified to have een affected.C. Maintenance was in-serviced on the requirements of life safety code K069.D. Monitoring of this plan of correction will be the direct responsibility of the Executive Director/designee. Observational audits will be	10/22/2011

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	1998 Edition, 2-3.2 requires fire extinguishers provided for the protection of cooking appliances use combustible cooking media (vegetable or animal oils and fats) shall be listed and labeled for Class K fires. 2-3.2.1 requires a placard shall be conspicuously placed near the extinguisher which states the fire protection system shall be activated prior to using the fire extinguisher. Since the fixed fire extinguishing system will automatically shut off the fuel source to the cooking appliance, it is preferential to activate the fixed system before using a portable fire extinguisher. In this instance, the portable fire extinguisher is supplemental protection. This deficient practice could affect 12 residents on 400 southeast hall as well as visitors and staff. Findings include: Based on observation on 09/22/11 at 2:08 p.m. with the Maintenance Supervisor, there was a Class K portable fire extinguisher in the south end of the kitchen which lacked a placard. Based on interview on 09/22/11 at 2:10 p.m. with the Maintenance Supervisor it was acknowledged the Class K portable fire extinguisher lacked a placard. 3.1-19(b)		conducted 1 time weekly for 12 months and results will be taken to Performance Improvement meeting monthly until such time the committee recommends discontinuation of monitoring.E. 10-22-2011	